Expression of Interest – Policy Prototype CCIN Funding

CCIN Member Authority: Tameside Council

Name of CCIN Lead Member: Cllr Dolores Lewis

Name and Job Title: Assistant Executive Member

1. What is your idea?

Living Well at Home (LWAH) – Tameside Council

Tameside Council is working to improve the quality of care and support that vulnerable people receive by maximising the choice of support available and by creating better quality of life and experiences for individuals. As part of the Living Well at Home programme, we are committed to enabling local people to remain well and living independently in their own homes and communities of choice. Younger adults and older people who, because of long term health conditions need additional support, can expect a good quality service that is person centred and meets their needs, is available when it's needed and is sustainable. To achieve this in the context of long-standing financial pressures and increasing demand, we have embraced innovative opportunities and support solutions.

Whilst Living Well at Home will continue to assist with the practical help that people need, it is committed to changing the way this support is provided; shifting the focus of care away from tasks and back to the person. Changing the way support is commissioned will, in turn, enable a more collaborative relationship between the person needing support and the staff providing that support; putting the individual at the centre and, wherever possible and appropriate, exploring options that are not necessarily all about paid support.

Living Well at Home is very much a model still in development and while progress is now advanced with our work, we hope that it still satisfies the criteria for the CCIN policy prototype.

2. Who will you work with?

In partnership with the Tameside Integrated Care Foundation Trust, the Tameside & Glossop CCG and the Local Care Organisation we have ensured that this model is pioneering a way of working with ensures home care is no longer delivered in silos and that providers can explore new possibilities for this innovative and new model. Our current list of providers include Able Care and Support, Careline, Comfort call, Creative Support, Direct Care and Medacs.

These providers are working more collaboratively with social work and district nursing colleagues as well as with community groups to ensure people's outcomes are met in ways that best reflect their particular needs and circumstances. We have co-designed a Greater Manchester Quality Model which represents a shared vision for improving quality of life, quality of care and partnerships across health, Social Care and communities – this is being developed into a full exemplar model, ultimately creating a model for a region wide quality kite mark adult social care. The quality theme has chosen the following piece of work as its trailblazer: Nutrition and Hydration (with links to oral health) in a homecare setting - work is progressing with Age UK, the Oral Health team, the personalisation team and Dementia United to build on existing training to empower front line care staff to identify malnourishment and dehydration

Tameside Council are working with the regulators to ensure good communication and joint working alongside relationship building and working in partnership with Independent Care Sector Network providers. We are also working in partnership an Independent Inquiry into Care at Home to ensure that the recommendations of the citizens' jury are informing the priorities of the programme.

3. What are the outcomes you hope to achieve?

In transforming the way people are supported at home - our aspiration is better, closer integration of services. For example, our West neighbourhood District Nurses are piloting closer collaboration with support at home providers in regards to pressure care. District Nursing RAG ratings and body mapping is shared and used across the two services, underpinned by training for care staff taking on these tasks. Once this is rolled out and bedded in, further tasks will be identified over the course of a 12-month pilot.

Essentially, the new model means support providers have a different relationship with the people they support. Providers are tasked, where possible, with helping users realise their assessed outcomes differently and not necessarily always via direct 'homecare'. Despite the shortcomings of, and problems with, the 'time and task' system, lots of good, person centred support is nonetheless provided. The intention is to build on this and ensure person centred approaches become the norm rather than the exception as providers adapt to using commissioned hours more flexibly and co-producing support with individuals.

4. How does your project support the aims and objectives of the Co-operative Councils Innovation Network?

The current homecare system needs transforming to deliver better, service user focussed outcomes, in a sustainable system. Tameside is at the forefront of this transformation. Co-production is at the heart of this new model, service users and employees are part of a conversation unlike any other across the country. This is innovation putting residents at the heart of the services we provide. Transforming support at home in Tameside is having a significant impact on the lives of some of our most vulnerable residents. We are moving from care as a back stop or safety net, to care as an enabler of lives and a re-invigorator of individuals.

The 'time and task' model is no longer fit for purpose – rushed calls and call cramming are unsatisfactory for service users and care staff alike. Financial pressures mean homecare providers are struggling to recruit and retain staff to meet demand levels. Poor pay, low levels of job satisfaction, the negative image that has unfortunately developed around care jobs and the lack of career progression are all contributory factors.

Furthermore, by increasing the responsibilities of homecare staff, underpinned by improved pay (linked to skills development) we will continue to offer a career rather than just a job in care. This is especially important if younger people are to be attracted; essential given a generally ageing homecare work-force. Benefits across the wider health economy include fewer people moving into residential or nursing care, fewer hospital admissions, fewer presentations at A&E, more experienced people moving on into social work and nursing or moving through into management roles in homecare.

We have implemented a Workforce Deal which seeks to attract and retain care workers by ensuring that employment arrangements meet the minimum standards expected when compensating an individual providing a fundamental public service. Low pay has long been recognised as a key factor in recruitment difficulties and the amount of movement across the sector - A comparison of information from 2017 – 2019 has noted that all localities, have increased rates paid to providers and also stipulated a minimum hourly wage rate within their cost models, in contracts and through ethical frameworks. Increasing hourly rates is always likely to create an early impact on recruitment and retention, and in some localities, they report that this has noticeably reduced turnover and in particular reduced movement of staff between providers.

We have a clear plan for further improvements that will improve the workforce deal for social care staff. These are centred around reviewing rates paid to providers which will drive up hourly rates paid to staff, better workforce planning and building ethical employment standards into contracts whilst focusing on workforce development. There is a clear perception from those now working in `zones' that this shift has been positive from a workforce perspective, some are already working in this way and some are moving in this direction. Other areas of good workforce practice are being implemented, or are in plans, that are expected to enhance these improvements and create further stability of the LWAH

workforce. These include the adoption of UNISON's Ethical Care Standards Charter which will require providers to evidence that they pay travel time and costs, and time to attend training, and move away from 'time or task' delivery to more person centred care provision and support through local workforce development programmes.

5. How does your project demonstrate the Values and Principles of the Co-operative Councils Innovation Network?

Equality, solidarity, honesty, openness, social responsibility and caring for others are all values central to the Living Well at Home model. In developing this model we have been careful to ensure care providers have the time to adapt to the new approach, become familiar with co-producing and sequencing support plans, and are comfortable with working more flexibly and creatively to help people achieve their outcomes.

Providers are able to use commissioned hours flexibly where need be to support people to engage with a local community group or activity; some initial hand-holding for instance, where someone is anxious and just needs a little extra support. For people who are recently bereaved, long-term socially isolated or where carer stress is an issue, taking part in an activity or group could make all the difference in terms of their sense of wellbeing, independence and self-care. And, for some people, the need for direct homecare support may be reduced. All six providers are signed up to the key worker approach. Whilst long established in learning disability services, it is little used in homecare. Providers use a range of models, but all are variations on a theme – workers are matched with a small, manageable number of people, usually people they routinely support and have long-standing relationships with.

We have looked at many care plans and redesigned them with the service users to reduce the amount of calls they require; and to create new calls (without increasing their weekly hours of care). We regularly keep abreast of community initiatives and groups in the area and share this with our service users at review points. This has resulted in several service users accessing the community in a way that they have not before. We have also referred service users to the social prescribers and the neighbourhood pharmacy team. We also regularly talk to our service users about different transport options and several have applied for travel vouchers as a result which has reduced the cost of their travel enabling them to leave the house more often.

The best way of explaining the impact of our asset based model is to list qualitative examples from some of our workers about what it means for the people they support:

- Jenny was really worried about her MS as she had little understanding of the condition and did not know how it would progress. Jenny was particularly concerned about losing her remaining mobility. I contacted the MS society and they sent out various information packs including an exercise pack and an accompanying DVD. Jenny has been watching the DVD and completing her exercises in her chair.

- Ann has reduced mobility in that she can only walked short distances but she has a mobility scooter. I spoke to Ann about all the community groups that are available on her doorstep and with regular coaxing and by developing strong links with people running the community groups, Ann started going out more regularly. Ann's daughter also previously did Ann's shopping but is unable to do so following a recent accident. The carers are now going to take Ann with them so she can do her own shopping for the first time in years.

- Maureen has a diagnosis of dementia and has been receiving support from the hospital's day centre. She found the cognitive activities helpful however this was short term support which eventually came to an end. Maureen and I discussed how she could incorporate cognitive activities into her daily care with her carers and I purchased a programme called the 'Japanese Memory Group' which provides guided sessions to improve memory and cognition.

6. How will you share your learning with the Co-operative Councils Innovation Network?

We will be seeking to convey demonstrate the benefits of the model through existing regional bodies such as the Greater Manchester Combined Authority and the Greater Manchester Health and Social Care Partnership. Through this interaction we would be hoping to engage Salford, Oldham and Rochdale Councils further in exploring the benefits of the programme as it progresses.

We would seek to present on this programme as a report to the CCIN at the appropriate time, seeking to see it included in the next edition of the CCIN prospectus. We are also working with Kirklees Council as a support partner in with this project, as they are bidding also. Throughout 2020 we would also hope to engage in CCIN events to present our findings and discuss our progress in more detail.

Additional information

A recent video documenting the progress of the Living Well at Home programme can be found on Vimeo via this link:- https://vimeo.com/368759639/3b54c5d0c1